

Medicine, Power and Social Legitimacy

A Socio-Historical Appraisal of Health Systems in Contemporary India

Medical pluralism has been defined as the coexistence of several medical systems and the relatively greater choice available for everyone. However, a key issue in medical pluralism in India is the existing unequal power relations between different medical systems as well as between “providers” and “receivers” of healthcare. Hence, in order to understand the dynamics of medical pluralism and to analyse current health seeking patterns in India, one needs to trace historically the conditions under which the dominant medical systems emerged and also understand the social bases that sustain these systems.

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In post-independent India, efforts to deliver modern healthcare in terms of institutional structures, qualified practitioners, and health policies at national level have been well documented. Although there has been considerable improvement in the health status as measured by the increase in life span (33 to 62 years), fall in infant mortality and the crude death rate, statistics also show that such achievements have fallen far short of the nation's expectations. United Nations provided statistics reveal that in sub-Saharan Africa and Asia, millions of people still die from communicable but preventable diseases like tuberculosis, malaria and schistosomiasis, besides the scores succumbing to newly emerging diseases such as Severe Acute Respiratory Syndrome (SARS), bird-flu, chickungunya, and dengue. About one-third of the world's population is infected with TB with almost two-thirds of them living in Asia. In the developing world, 1.2 billion people lack access to safe water, adequate sanitation and poor housing, 800 million people lack access to health services [All India People's Science Network 2002].

That health services have been dismally poor and inaccessible for a large majority of the population in India has not been disputed. This has been adequately acknowledged recently by government of India health policy documents as well [GoI 2002, 2005]. One of the arguments in health sector debates is that lack of adequate institutional health services leads to ill-health and continuing mortality and that superstition, irrationality, ignorance continue to haunt rural India and hence the high levels of ill-health and mortality. Accordingly, there has been an on-going debate in explaining reasons for inaccessible health services. This debate manifests at various levels: public health sector vs private health sector¹ (and its related arguments globalisation vs localisation); modern health system vs traditional/indigenous/alternate systems of medicine (allopathy vs ayurveda, unani, siddha, etc), and rational vs spurious medicines. Of late, holistic/unified models have been advocated instead of binary models say, for instance, public-private partnership in healthcare² including non-government organisations (NGO) sector, and integrated medicine that is supposed to be a judicious mix of various systems of medicine. Thus, impassionate arguments have been made in support of each of these, offering evidence, explaining the complexity of prevailing disease-producing conditions, the present disease

burden, the existing health infrastructure and its linkages with the hierarchical and iniquitous social structure, thus justifying scores of single disease vertical programmes in the country.

In brief, the “inaccessibility to primary healthcare”, “pathetic situation of community health centres” (CHCs), and “advanced stage” of decay of health services system in the country [Mukhopadhyay 1997] have been explained by social scientists. Their explanations can broadly be grouped under three theoretical perspectives: the colonial theory of supremacy, theory of privatisation and globalisation; and the theory of discriminatory continuities and consistency.

The advocates of colonial theory of supremacy argue that the indigenous systems of medicine have been sidelined and subjugated by the hegemony of the western system of medicine. This has been done through conspiratorial methods adopted by the colonial rulers in India. It is in fact the colonial rule that ushered in the allopathic (western) medical system in India and hence it became a state-imposed healthcare system both during colonial and post-independent India. Western scientific medicine has been imposed both as an ideology and practice in India. In their attempt to embark upon modernity, the ruling classes here accepted the western bio-medical system in toto leading to the marginalisation of Indian medical knowledge systems. This approach of the colonial state has had implications for all health policies followed in India to date [Arnold 1993, 2000; Mark Harrison 1994; Radhika Ramasubban 1988]. The protagonists of the theory of privatisation and globalisation argue that it is essentially to do with the way capital has subjugated medical science, which has led in turn to the commodification of health, and technological medicine (specialty and super specialty medicine). In the process, drugs have become more powerful than the providers, which has resulted in corporatisation of medical care and increased disparities between specialised and generalised medicine. By implication, the capitalist character of Indian society continues to distort the potential contribution of scientific medicine and this has led to the aggravation of suffering and alienation of the poor [Banerjee 1984; Qadeer 1985]. Most of the explanations regarding inequalities of healthcare in India fall either within the first or second perspective, however, one also finds a combination of the first and second perspective as an analytical

tool in explaining health inequalities. The third perspective, i.e., the theory of discriminatory continuities and consistency is not as explicit an explanation but certainly can be inferred from various research studies [Zysk 1998; Whitehead 1995]. This theory points out that external factors, whether colonial or imperialist forces, may have certainly posed as sources of disruption but to place everything under their rubric may be quite an exaggeration. A thorough and critical investigation of internal factors and social forces that has led to iniquitous healthcare has not been undertaken in India. In medical anthropology and history, the response has been that while documenting or dealing with the “co-existence” of varied medical traditions and practices, we must not ignore or underplay the issue of power, domination and hegemony, and must locate our work in a larger historical, social and political context *within each nation* [Waltrand 2002; Nichter and Lock 2002] (emphasis author’s).

Taking clues from these theories particularly the third one, this paper argues that the very process of institutionalisation of medicine/health services within a nation-state offers explanations pertaining to the iniquitous healthcare in India. Any democratic institutionalisation of medical systems would mean the inculcation of new social values within existing institutional structures. Here the purpose is to highlight how the institutionalisation of health systems has taken place within the pluralistic medical tradition in India. The concept of social legitimacy is used in this paper to explain how certain social forces continue to make and impose certain exclusions and inclusions within the social order, in effect giving legitimacy to (or therefrom) and thus constituting that very social order. Institutionalised medicine has acquired a legitimacy because of its scientific credentials based on dominant ideas, methods of validation and textual sources. This legitimacy is further justified on the basis of the patronage derived from two sources – one from the state and the other from civil society, both of which in turn need to be located within the social matrix of caste and class [Nichter 1986; Pati 1996].

In order to analyse the current health scenario, a historical sociology perspective has been adopted. The structure of the paper is in three sections, the first section is a historical account of indigenous medical systems more particularly ayurveda and the circumstances of its patronage by various rulers in pre-colonial India. Introduction of western medicine³ in the colonial period, the resulting competition between Indian systems of medicine and western medicine and the axis through which a dominant system emerged have been outlined in Section II. Developments in health sector, particularly factors leading to the further widening up of the space between different systems of medicine, exclusionary policies and practices prevailing in the institutional set-up in the post-independence period have been traced in the third section. This is finally followed up with a discussion summarising and analysing the processes leading to iniquitous healthcare in India.

I Early Indigenous Systems

The reference to plural medical systems cannot be complete without a discussion on ayurveda and unani in India. Apart from scattered references to monastic or university education in medicine, the study of medicine involved apprenticeship with a teacher as a resident in the latter’s household [Kutumbaiah 1962:xlix]. A major criterion followed by the teachers was to

admit students of the same or a closely related caste in order to maintain the principle of purity-pollution in eating arrangements and other caste restrictions. Perhaps for this reason different regions tended to have dominant medical castes. Vaidyas, a vaisya caste, are dominant in Bengal but a brahmin sub-caste provides most ‘vaid’ in Kerala [Zimmerman 1999]. Training in unani medicine was also carried out in the “personalistic, informal settings of family homes and apprenticeship” [Metcalf 1985:4]. Again, quite apart from the need to learn Arabic, this tended to restrict unani education to upper class Muslims.

Of course, within ayurvedic medical system there existed both formally trained medical practitioners who needed seven years of training before they could start practising and healers who practised ayurvedic medicine in a more informal manner. These latter physicians residing in rural India mostly treated their patients with medicines based on herbs and natural products. Prior to the establishment of ayurvedic medical colleges in modern times, ayurvedic knowledge was normally passed on within families among male descendants. Since the establishment of ayurvedic colleges, the transmission of the tradition has become more open, but the Sanskrit component remains central and the modernised ayurveda, like its traditional transmission remains largely in brahmin hands [Trawick 1992].

The period of the Brahmanas and the Upanishads⁴ (800-600 BC) is considered to be a time of great mental ferment. As a result of the new ideas and theories developed during and after this period, there developed rationalism in every sphere of civilisation. The origin and spread of Jainism and Buddhism in the 6th century BC actually influenced the thinking of the intellectual class. Gradually the medicinal system broke loose from that of popular tradition and began to develop independently; medicine became empirico-rational. This change is attributed to the influence of the emerging new schools of philosophy [Hymavathi 1993].

The Buddhists were deeply concerned with human suffering and illness. It was the Buddhists who borrowed the concepts of ayurveda and with Buddhism these concepts reached China in the 2nd/3rd century AD [Deshpande 2001]. The Buddhist monasteries were places of meditation but they often also included a sickroom. It is likely that these developed into hospitals serviced by monks, housing not only the sick but also offering shelter to the poor and destitute. Ayurveda while enunciating a great number of ethical norms on life and style of living, unhesitatingly advocated the use of meat and alcohol as “therapy” in certain conditions. Historical studies suggest that soon after Susruta, the practice of surgery by traditionally trained ayurveda physicians declined and that surgery came to be practised by barber-surgeons.

The caste system, which steadily increased in complexity in the first millennium AD, might have created taboos concerning close physical contact with “untouchables” or those of the lowest caste. Surgery, which involved such physical contact would have thus lost favour, and its practice by traditional ayurveda may have declined. Yet, it was during this period that the importance of pulse examination, as also urine and the value of the body massage was emphasised in ayurvedic practice. The famous surgical procedure of removal of the cataract described and practised during Susruta’s time reached China, probably through Buddhist pilgrim monks and not through ayurvedic Indian physicians. By the beginning of the 20th century, surgery was described again, but more frequently carried out by barber-surgeons than

ayurvedic practitioners. Perhaps the practice of surgery either fell into disrepute or was disregarded by ayurveds who preferred only to heal through medicine [Udwadia 2000].

The sources show that ayurvedic medicine derived its major features from the work of heterodox ascetics rather than from brahmanic intellectuals and that most significant growth of Indian medicine took place in early Buddhist monastic establishments [Zysk, 1998]. Further elaborating this, Zysk says:

Even in the early Vedic period, physicians were outside the pale of the Aryan sacrificial cults probably because of their association with the Atharva veda, not yet considered a principal 'sruti' (revealed) scripture. Moreover, their frequent travels beyond the frontiers of Aryan society in order to acquire the rich pharmacopoeia mentioned in the Atharva veda brought them into frequent contact with non-Aryan peoples. Although physicians obtained from these outsiders much new and valuable knowledge pertaining to their special craft, these encounters caused them to be widely perceived as inferior, being polluted by contact with impure people. This attitude evidently existed from the early vedic period but received articulation only in the later Brahmanas, which provided the orthodox brahmanic means for accepting healers and consecrating their services. Their contact with non-Aryans might well have given rise to an empirical orientation that became, as Chattopadhyaya correctly points out, antagonistic to brahmanic orthodoxy in the later vedic period (Ibid, p 24).

Shunning the physicians and excluding them from the brahmanic social structure and religious activities implies that they existed outside mainstream society, and were probably organised into sects who roamed the countryside as indicated by the phrase "roving physicians".⁵ They earned their livelihood by administering cures and increased their knowledge by keen observation and by exchanging medical data with other healers whom they encountered along the way, for the ayurvedic medical tradition strongly encouraged discussions and debates with other physicians.

It is documented that the meat, blood, fat, liver, bones, urine, hair, secretions, bile, marrow, semen, horns, nails, bristles, hoofs and the bright pigment called "gorocona" of various animals were various products used extensively as drugs. The civet and products of various animals such as the cow, goat, monkey were the most popular and widely used animal substances [Hymavathi 1993]. However, the usefulness of animal substances extensively in the preparation of drugs was also contested. For instance, Ugradityacarya condemned animal sacrifice in the pretext of treatment. He propagated the uselessness of "flesh diet" and convinced the doctors who had assembled in the court of Amoghavarsa. He proved in his work *Kalyanakaraka* that animal substances though useful in treatment, are not absolutely essential and could be discarded by using in their place, many more powerful herbs as substitutes. But it does not seem that all physicians discarded the use of animal substances while preparing drugs. On the other hand, we find that they explained the usefulness of meat and other animal substances as diet and medicine (Ibid, p 181). Hence, the prescription of meat and alcohol finds a strong place in a ayurvedic texts.

Literary sources mention a separate community of people known as 'mandulavandlu' (medicine-men) who supplied source material for drug preparation in the Vijayanagar empire. The koya (a tribe in south India) were considered as medicine men as they were the people who lived by selling medicines. Similarly cencus (another tribal group), were famous as collectors of forest products. They largely collected animal substances such as civet, horns, teeth, bones and skin of various animals, and other vegetable substances such as 'carapappu', 'mumtamamidi'

and honey. The erukala and cencu women used to sell various kinds of medicines including some roots (Ibid, p 185). This indicates the significance of lower social groups particularly tribal communities who played an important role in the collection and supply of source material for the medicines.

Recounting how the then medical practitioners have been attributed with violence and impurity, Zimmerman (1999) says that the art of healing imposes the use of violence on the medical practitioner: violence toward animals if meat must be eaten, violence toward the patient if bloodletting, surgery, or obstetrics must be carried out. These notions of ayurveda have been abandoned in modern times.

A close scrutiny of sources from the 9th century BC to the beginning of the first millennium AD reveals that the then medical practitioners were denigrated by the brahmanic hierarchy and were excluded from orthodox ritual cults because of their pollution from contact with impure people. The literary works, particularly the late samhitas and early brahmanas, from the late vedic period (ca.900-500 BC) indicate that physicians and medicines were denigrated by the priestly hierarchy, who rebuked the physicians, their impurity and their association with all sorts of people [Zysk 1998: 22]. The orthodox mendicants and heterodox wandering ascetics who had abandoned society to seek liberation from the endless cycle of birth, death and rebirth and who were quite indifferent and even antagonistic to the brahmanic orthodoxy based on caste and ritualism. These heterodox ascetics generally known as 'sramanas' also had a penchant for more empirical and rational modes of thought.

Direct observation of a decaying corpse considered polluting by brahmins and the upper castes was the best and most valid way to gain knowledge of human anatomy for the specific purpose of demonstrating the Buddhist doctrine of impermanence, to the ascetic monks, but in addition, it afforded an empirical understanding of the human body. An empirical approach to learning human anatomy by dissection involving direct, first-hand observation of the body, was fundamental to ayurvedic medical knowledge and was also common to Buddhist ascetics' quest to understand the human body. A vast storehouse of medical knowledge developed among these sramanic physicians supplying the Indian medical tradition with the precepts and practices of what has come to be known as ayurveda. The first documented codification of this medical lore took place as wandering ascetics assumed a more stationary existence, cloistered in the early Buddhist monasteries.

Thus Hinduisation of ayurvedic medicine coincided with the decline of Buddhism resulting in magico-religious practices being re-imbibed as part of ayurvedic tradition. As Zysk (1998:26) points out:

The occurrence of this phenomenon may indeed correspond to the 4th or 5th century of the present era, when Buddhism was declining in India and the brahmanic religious tradition was making its resurgence through a radical reorientation of Brahmanism. Although considered to be extremely polluting and defiling, medicine was now included among the Hindu sciences and came under brahmanic religious influences, perhaps out of necessity as the need for the healing and care of the sick and injured cut across the existing social and religious barriers or more likely as a result of the general process of brahmanic assimilation.

Paradoxically, it is Hinduism that assimilated the ascetic medical repository into its socio-religious and intellectual tradition, beginning probably during the Gupta period and

by the application of a brahmanic veneer that made it an orthodox Hindu science. The upper class intelligentsia tuned to the discourses of science and colonial power/knowledge system turned away from and virtually condemned indigenous knowledge systems. Along with this condemnation, there were attempts to appropriate indigenous methods. For example, the treatment of snakebite, with the indigenous method of cutting up the wound and sucking out the blood was given ritualised brahminical slant. The treatment of snakebite was traditionally mastered by the lower castes. When the brahmins tried to appropriate the method, they suggested the same procedure of treatment accompanied by certain mantras during the treatment. The treatment was thus not only taken over but recast with mantras associated with “high” Hinduism [Pati 1996]. There was the endeavour to draw out and recast the indigenous system of medicine. This latter aspect needs to be viewed within the larger paradigm of caste and class. For instance, the reference to the ‘nichalokas’ (lower castes) implied looking down at castes like kelas (snake charmers) who treated those bitten by poisonous snakes (Ibid, p 29).

During the medieval period, temples and ‘mathas’ were the two important institutions which protected the culture and life of the age. These institutions maintained learning centres as well as hospitals for the promotion of the science of medicine. In most of the village temples, the priests were the physicians also. But in big temples, which were located in big villages, towns or ‘agraharas’, a part of the temple was allotted for taking classes and for the maintenance of hospitals. The temples maintained learning centres where ayurveda was taught to the students both theoretically and practically by maintaining hospitals in the temple complex. In the Deccan and in the south, between 6th and 9th centuries, there is evidence of village dispensaries often close to the temple complex. In the Chola period (AD 900-1200) dispensaries were termed ‘vaidyasalai’ – vaidya meaning medicine and ‘salai’ meaning a charitable institution. There were numerous such dispensaries manned by local physicians, whose posts were often of a hereditary nature.

Nityanatha Siddha of 14th century and Gaurana of 15th century wrote that there were students who were helping their preceptors in preparing mineral drugs. The main Golaki Matha during the reign of the Kakatiyas, was situated in and around Mandadam village. In that matha, there was a college consisting of brahmins who were well-versed in the vedas as well as in grammar, logic and literature. Five of the brahmins were scholars especially versed in philosophy. A physician with nurses and clerk was appointed in the hospital built there with two wards, i e, general and maternity [Hymavathi 1993:145-6].

This process of religious slant to the ayurveda was further consolidated in mathas, temples and agraahas during the medieval period. Hindu monastic institutions also followed the Buddhist model and established infirmaries, hospices, and eventually hospitals in their monasteries. However, one also finds counter-evidence where the barbers were granted some noticeable privileges during the reign of Vijayanagara rulers. In 1547, there is some evidence to show that barbers were skilled in the art of healing certain diseases such as rheumatic pains of the body, blood related diseases, eye-diseases etc. It might be in recognition of their skill in this art that the barbers Kondoja and his son Bhadroja were given privileges and were granted a ‘manya’ land. These people might have requested the ‘Raya’ to extend the privileges to all the members of the community. But, it is reported that the learned physicians did not like the

barbers, the gollas (sheperds), the malas (dalits) and others taking up healing as profession [Rao Rama 1986]. It must be because of this reason that they followed their traditional methods without the knowledge of the sastras. The fact that these traditional methods with some modifications continue till today, especially cataract operations, piles treatment and the healing of jaundice makes us think that these practices gave good results and gained in favour on account of their efficacy and the resulting easy relief.

As evident, ayurveda did possess a highly abstract meta-theoretical framework in explaining diseases. This framework existed not only with adequate empirical verification, but was grounded in well-recognised procedures of validation and experimentation. However, the strong principles about ayurvedic medical system – rationality, empirical observations, sharing knowledge in the public domain, serving the needs of sufferers, were weakened with the limited patronage it received from successive rulers and when vested interests of a select social group gained control over the medical system in the pre-colonial period. Hence it can be inferred from this historical account that the scientific basis of ayurvedic medicine flourished not simply under Buddhism but in an ambience of castelessness or the denial of varna where knowledge production was for the public good. The scientific content as well as the wider dissemination of ayurvedic science were restricted when caste came to ascendancy through brahminism. As Varma (2006) pointed out, first the advance of ayurveda was hindered by the brahminical culture, which exerted adverse effects not only on medicine, but also on other scientific pursuits. One characteristic of brahminical culture is that knowledge must only be transferred to deserving select pupils and not to the general public. Buddhism tried to break this mould and started more accessible learning institutions but Buddhism lost ground in India, partly by force and partly because it was not mystical enough. The guru-shishya (teacher-pupil) culture is ingrained in every science and art form. It even influenced Muslim practitioners of unani medicine and classical musicians. Any knowledge, which is not transferable is doomed, it cannot evolve into a living science.

In the latter part of the story, ayurvedic medical system, its trained practitioners as well as folk practitioners have been further marginalised during the colonial rule since the interests of the colonial rulers as well as the Indian elite worked diametrically opposite to indigenous systems of medicine.

II

English Medicine in Colonial India

The British imposed western medicine on the colonised people of India, as part of their civilising mission. The Nobel prize winner and malarial scientist Sir Ronald Ross, had boasted in 1923 that the British had introduced into India, “honesty, law, justice, order, roads, posts, railways, irrigation, hospitals and what was necessary for civilisation”. It became increasingly difficult for indigenous systems of medicine to compete with the highly favoured western system. As several scholars have pointed out, whenever there were pressures on the British to recognise ayurveda and unani, they insisted on scientific evidence of safety and efficacy and “privately” they believed that to place these systems on a scientific basis would be to destroy indigenous systems utterly [Jeffrey 1977:570]. No doubt, western medicine gained its recognition primarily due to the establishment of a new “tropical medicine” based on the germ

theory of disease, and a corresponding intensification in state medical intervention in India. The value of India as a tropical observatory, where diseases as varied as cholera, dysentery, leprosy, and malaria could be more practically or effectively investigated than in Europe was widely acknowledged. The inability of western medicine to identify the precise cause of ill-health encouraged practitioners and others to situate disease, especially epidemic disease, within the wider physical and cultural landscape of India.

Biomedicine in the world developed while different European countries were colonising the world – a situation that would, much later during the 18th and 19th centuries, explain the presence of biomedicine in different colonised lands. The development of biomedicine also occurred at the moment in which the European capitalist system was establishing its foundations. A review of the history of western medicine in India indicates that it was far less successful despite state sponsorship and regulation even after 150 years of British rule. As David Arnold (1993) states:

One of the explanations about western medicine's lack of acceptability in the beginning was that it had remained too closely identified with the requirements of the colonial state and so was remote from the needs of the people. It had failed to make the transition from state medicine to public health. Another explanation was that the mass of the population remained content with the innumerable and readily accessible practitioners of indigenous medicine – the 'kavirajas', the 'vaidyas', and the 'hakims' – and either saw no reason to seek out the few western-trained practitioners who were available or could not afford their fees.

The second explanation of Arnold about the kavirajas, vaidyas and hakims serving the masses is a serious matter of contention. Prior to the arrival of British, native medical systems (ayurveda, unani, tibb, etc), particularly the trained medical practitioners served the affordable sections, mainly the ruling classes and upper castes. It is the various folk practitioners particularly the herbalists and faith healers in every local community, who were widespread and served the vast majority of the poor.

There is widespread generalisation about ayurveda in rural India as if the response to illness by the lay population invariably reflects an ayurvedic approach to healthcare. There is no doubt about the fact that ayurveda and folk medicine share points of commonality, e.g., a concern about body heat, a hydraulic model of the body, concern about the blood and digestion, etc. As Mark Nichter (1986) rightly points out, it is the discrete ayurvedic practices and medicines and not a systematic ayurvedic model of health and pathology, that influence popular health-care behaviour. The notion that systematic ayurvedic therapy, based upon ayurvedic diagnostic principle, is readily available and inexpensive in village India is unfounded. This myth is propagated by surveys, which classify all herbal practitioners as practitioners of ayurvedic medicine, is misleading.

However, discussing indigenous medicine, Kumar points to the crisis of confidence that affected ayurveda and unani once western medicine became established [cited in Pati and Harrison 2001:30]. The average social position of the elite vaid and hakims probably deteriorated during the British rule. Until the first world war medical college students were recruited from a relatively narrow social background with Christians (often European and later Anglo-Indian) and Parsi students (in Bombay) providing a disproportionate share of the student body. The over-representation of Indian Christians and of Parsis was stable until the first world war, and suggests "both the strong symbolic value of the degree as an index of westernisation and

the strong identification of these groups with westernisation in this particular form" [cited in Jeffrey 1988: 84].

It is through medical education, particularly induction of the children of kavirajas, vaidyas and hakims as western-trained doctors, that gave legitimacy to its hegemony. Hence, it has been pointed out that after 1914, the future of western medicine in India lay not with Europe's colonisers but with India's emerging elites. The indigenous doctors were the vital intermediaries in the promotion of western medicine and surgery, for instance, as seen in the Bombay Presidency [Ramanna 2006: 3221]. Although the "cultural authority" and hegemony of biomedicine over indigenous "science" and knowledge were initiated by the colonial state, they were extended by the mainstream national leadership and national government (particular social forces) with far more extensive and profound implications and less resistance [Arnold 2000; Khan 2006].

The British were very conscious of protecting the interests of the upper caste/classes and used it as a strategy to veer them out of the indigenous/native medical systems. This has been quite well demonstrated in their health surveys and vaccinations undertaken on the Indian population. For instance, the cholera vaccine trials entailed a detailed recording of cases and deaths among the inoculated and uninoculated separately, as well as different information according to the body population during the colonial period. In the North-West Provinces (Oudh and Punjab), the inoculation registers containing individual names, father's names or regimental numbers, sex, age, nationality, birth-place, religion, caste, profession, address and date of inoculation were deposited in the bacteriological laboratory in Agra. The religion or the caste of inoculated persons was also mentioned in records such as, for instance, "Radhamoni Dassee, Hindoo" or "Shaikh Baboo, Mohomedan". The number of brahmins inoculated was apparently considered especially noteworthy, as may be seen in details of inoculated persons given in Haffkine's report where no other caste but that of the brahmin is specifically mentioned – Agra, 580 (117 brahmins), Rawalpindi, 164 (20 brahmins), etc. It is clear from the kind of information elicited that a certain imagination of the social order determined the course of the operations and the way in which scientific as well as administrative recording was done [Misra 2000: 3894].

Of significance is that the upper caste and class base of indigenous systems of medicine shifted to western medicine as well, and subsequently the interests of this social group were entrenched in healthcare policies rather than the health needs of vast majority of the Indians. However, medicine's role as a "tool of empire" and as an instrument of "social control" that was part of the colonising discourse has been well documented in the historiography of public health in British India, which led to the domination of western medicine over indigenous systems of medicine.

III Post-Independent India

Without much debate, British rule ensured that allopathic medical system became the mainstay of health services⁶ in post-independent India through the Sir John Bhore Committee. The question arises, why did the allopathic system of medicine have such a smooth sailing while the marginalisation of indigenous systems of medicine take place in post-independent India. Conformity to biomedical

ideology and practice was demonstrated by the Indian ruling classes and upper castes who not only owned up to the responsibility in carrying it forward but it was eulogised as a sign of modernisation. Within the nationalist imagination, Gandhi said, his motto was “self-reliance” (‘swawalambana’) which is possible only where there is self-health reliance (‘swasthyawalambana’). “To deepen modern (English or western) medicine is to deepen our slavery” [Gandhi 1993]. However, it is paradoxical that despite nationalist leaders such as Mahatma Gandhi’s advocating swawalambana and swasthyawalambana, the institutionalisation of allopathic medicine has taken place without much debate.

In effect, there are three streams of health providers that have emerged in the post-independent India – qualified allopathic doctors, the qualified doctors from the Indian systems of medicine (ayurvedic, unani, homeopathy) and unqualified health providers (UHPs). The qualified allopathic doctors (both working in the public and private sectors) occupy the dominant position in the plural medical systems in India. They have demarcated for themselves spatial and social areas of health services largely within urban India and partially rural India catering to the affordable social groups. Qualified doctors from the Indian systems of medicine, in trying to compete with qualified allopathic practitioners have been relegated to a subordinate position in the plural medical system. They have been operating within more or less the same spatial and social boundaries, providing health services with the help of either their own chosen medical systems or combining their own field with that of allopathy. Both these institutionalised forms of medicine in public and private sectors cater to the affordable groups (20-25 per cent) which has turned out to be an expensive and unaffordable proposition for the vast majority of the poor. It is the third stream, i.e., UHPs who by default have become the mainstay of health services for about 75 per cent of the population in India.

A significant question arises, why are these UHPs still sought after in villages instead of the “free services provided by public health centres”, run by well-qualified and competent medical professionals, leave alone qualified private practitioners (allopathy or ayurveda/unani). The cost of treatment, which is, supposedly “free”, often exceeds the cost of going to an UHP. Several studies have also pointed out that apart from the cost of treatment, it is also the reluctance of qualified practitioners to serve the poor-sick, referral systems remaining ill-developed, medical education not reoriented and reformed to suit the needs of Indian masses, and the way preventive programmes remained unintegrated. What is more important, the manner in which the democratic concept of “primary healthcare” has been operationalised in the Indian context needs to be analysed.

Hierarchy and division of work is unavoidable in any organised set-up. In the Indian setting, however, this is further complicated since organisational hierarchies are to a large extent reproduction of social hierarchies present in the larger social system. A majority of the doctors come from upper caste/class background while the nurses and other field staff from middle or lower castes and classes with a few exceptions. Apart from their class backgrounds, the health personnel reflect the domination of certain castes. Despite reservation for the SCs and STs, those sections still remain underemployed in the health services. This replication of social patterns brings with it certain other traits as well, one of which is the upper class (elite) culture that pervades healthcare institutions. Institutional

rules have been framed and practised more according to the needs of health personnel rather than according to the social needs of the communities [Qadeer 1985]. Hence in accessing health services, social status rather than disease status appears more important.

Mark Nichter (1986) through his study in the south Kanara region argued that medicine constitutes an arena wherein the caste hierarchy in south Kanara is largely reproduced. Undeniably, caste serves as a factor undercutting or intensifying issues of professional status as well as personal economics. He concludes that issues of a doctor’s professional status and the relative caste power of staff within the regional health bureaucracy influence team work within local health centres. In essence, these institutions that were supposed to be part of a larger modernisation process through “inclusion” approach actually follow “exclusionary” practices. Although poverty and educational status are usually linked with the low health status of rural communities, it is essential to understand the way in which social hierarchies are mapped onto medical organisational hierarchies, which is an important factor in providing access to healthcare. As Varma (2006) argues, where public health is in disarray in favour of modern private profit-making hospitals in major cities, the marginalised population has little to choose between an allopathic and ayurvedic/unani doctor. This does indicate how in the post-independence period, the ruling classes articulated the need for establishing modern institutional structures in public space; however, the same social forces effectively contributed to the dilution of the spirit of these institutions in practice.

Given the above situation, one needs to look at whether rational choices exist for a large majority of the people, since India is projected as a living example of medical pluralism. Meera Chatterjee based on studies from four states (Bihar, Madhya Pradesh, Haryana, and Maharashtra) indicated that a significant proportion of rural illnesses are untreated by any means, and certainly by medicine, be it traditional or modern [cf Rhode and Viswanathan 1994]. Thus the debate in the health sector, about the choices for the poor-sick in terms of public or private healthcare, ayurvedic or allopathy, modern or traditional, does not provide any great clarity in terms of treatment-seeking patterns in India. The choice at one level in the plural medical systems is no choice at another level. The poor-sick are not only deprived of basic health services but also other basic needs like proper food, drinking water, sanitation, etc. Without understanding the circumstances of social life, it may not be possible to deal with health issues [Prasad 2000, 2005].

This paper argues that starting from the pre-colonial period, there is evidence of institutionalised forms of medicine (both allopathy and ayurveda) adapting deliberate and exclusionary policies that led to the vast majority of the poor-sick being alienated and marginalised in terms of health services. Unless modern social consciousness (egalitarianism) becomes the predominant driving force, the conditions for the emergence and spread of modern society may not emerge.

Discussion

In analysing the contemporary health situation in India, arguments about inaccessibility of healthcare to the masses are broadly placed within the context of tradition vs modernity. Protagonists

of tradition argue that it is the predominant biomedical discourse that is trying to ascertain its hegemony and control over the body population, in order to prove/establish not only its epistemic, pedagogical methods, etc, as superior but also to dismiss existing knowledge systems as irrelevant or non-scientific. Different sets of arguments are made in this paradigm which include: tradition is capable of innovation, tradition includes modern elements over a period of time implying tradition is dynamic; tradition caters to the existing needs of local communities;⁷ tradition is not anti-modern but is context-sensitive. The protagonists of modernity argue that it is the time-tested clinically proven scientific knowledge systems that are capable of providing universal healthcare to the masses. Modernity is capable of transcending the local, regional, and parochial boundaries. Thus, implying that it is only the modern nation state, which in principle can facilitate welfare (universal health, education, development, etc) to all its citizens without any discrimination. The pertinent question that is not raised is, why both traditional and modern medical systems in India, having more or less a similar social base, have been instrumental in gaining control over the “bodies” at different historical time periods but at the same time used the principles of “mystification”, “exclusion” in order to practise medicine. Instead of arguing why all the medical knowledge (traditional or modern) have not been democratised in order to ensure accessibility to the masses, the essential debate centres around the issue of hegemony and control⁸ by one system of knowledge over the other.

Therefore, medicine cannot be understood in its own terms as an objective science, since it also incorporates social values into its practice. Consequently it must be considered from a sociological perspective. Secondly, it is not technology per se but technological culture through which ruling classes and upper castes gained social legitimacy in India. The way westerners turned their white man’s burden, civilising mission, sanitation as civilisation into the project of modernisation/development in third world countries, similarly Hindu sanskritic elements and vedic rituals were turned into the project of nation-building by the upper castes and classes in India. All types of institutionalised medicine have become expensive including ayurveda and excluded a large proportion of people from accessing healthcare. The counterpoint would be to democratise all institutions that facilitate health services in India.

In India, a binary medical model seems to have been designed and put in place by the ruling classes for the benefit of dominant and dominated social groups. Although there is predominance of modern scientific medicine, folk, traditional and other indigenous forms of medicine, also co-exist. As part of the larger project of “modernity”, a conscious effort has been made to include certain social groups gain access with the institutionalised forms of medicine (both allopathy and alternate systems) while the non-institutionalised forms of medicine would anyway serve the purpose of the excluded and the under-classes. The non-institutionalised medicine, which is generally available to the poor-sick, is of poor quality because of its general subordination and exclusion from an organised system. Hence there is a need to analyse the internal social forces that continue to resist democratisation of institutional structures and continue to perpetuate the inhuman conditions and inequality, rather than exclusively and excessively focusing on external and global forces alone. What we need to investigate further in the health sector is about the institutional conditions

that sustain the inequality in healthcare in India. Thus, health has not been a choice but an imposed preference for a large majority of the population in India. 

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Notes

[This is a revised version of the paper, ‘Practice and Politics of Medical Pluralism: A Study of Healers in West India’ presented at the national workshop on ‘Mirrored Views on Healing Systems in India: Merging Policies, Politics and Practices’, held at French Institute of Pondichery, April 18-19, 2004. I am thankful to the organisers of the workshop and the participants for the feedback on the paper, especially Loren Pordie. I am grateful to Aloysius and Sudhakar Rao for their useful comments and suggestions that helped me revise the paper substantially.]

- 1 Promoters of public health advocate through “health for all”, “health for the millions” while private healthcare through “quality”, “efficacy”, “quick care”, etc.
- 2 The Canadian healthcare model is often cited as a successful experiment, which can be replicated across the world. However, the specific trajectory of healthcare in each nation is either ignored or undermined in advocating such models to be replicated. Also certain questions regarding forging partnerships between public and private are raised such as – is this a strength that India is not using adequately or is this what creates the chaos and the directionless movement?
- 3 Western medicine, English medicine, colonial medicine, imperial medicine are various terms used to denote a allopathic medical system that was introduced and practised during colonial rule in India.
- 4 By the time of Brahmanas and Upanishads, there were only four branches in ayurveda, i e, Bhutavaidya, Sarpavaidya, Rasayana and Vajkarana. During the transition period, four other new divisions came into existence viz, salya, salakya, kayachikitsa and kaumarabhrtya and are allied to ayurveda.
- 5 Regarding the statement that physicians in general are polluting and therefore excluded from the brahmanic sacrificial and social system, the *Satapatha Brahmana* also confirms that physicians (i e, the Asvins) were impure because they came into constant contact with humans in the course of performing cures. This attitude persisted in India and is found in the later law books that repeat passages from the laws of Manu, stating that physicians (‘cikitsaka’, ‘bhisa’) must be avoided at sacrifices and that the food given by physicians is, as it were, pus (‘puya’) and blood (‘sonita’) and is not to be consumed.
- 6 A strong plea for a rational approach, to the evolution of an integrated system of medicine in India was made in 1948, soon after independence, by the president of the Indian science congress. He tried to draw attention to the fact that the practice of modern medicine also had its unscientific aspects. Opinions were sharply divided on both sides. Modern doctors have generally opposed through their professional bodies, including the Indian Medical Association saying that any mixture of traditional and modern systems of medicine will jeopardise the growth of scientific medicine in India. Their overall opinion of traditional systems is that these are at best refined forms of quackery.
- 7 Community is generally constructed and used as if there is a homogeneous category existing in India across the country, region, and intra-region.
- 8 The hegemony of one system of knowledge on the other needs to be contested but within the democratic principles of working out an inclusive knowledge base and the institutional mechanisms.

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